Waiver Services - Waiver/Rehab Claim Form

FIELD NAME	INSTRUCTIONS
1. Recipient Number	Enter the recipient's nine-digit Medical Assistance identification number.
2. Patient Name	Enter the last and first names of the recipient who received services from the performing provider.
3. Primary Diagnosis	Enter the ICD-9-CM diagnosis code for the primary illness or injury for which the recipient was treated.
4. Secondary Diagnosis	Enter the ICD-9-CM diagnosis code for the secondary illness or injury (if any) for which the recipient was treated. If none, leave blank.
5. Procedure Code	Enter the five character HCPCS code that describes the procedure performed.
6. Modifiers	Enter up to three modifiers that apply to the HCPCS procedure code in Box #5.
7. Level of Care (LOC)	Leave blank.
8. Patient Liability	Enter the amount the patient must pay for each procedure.
9. From Date	Enter the beginning month, day and year of the service being billed.
10. Thru Date	Enter the last date (day) of the service billed. If the same as the previous field, leave blank.
11. OI Indicator	Enter "Y" if the service being billed is covered by any other insurance, including Medicare. Enter "N" if it is not.
12. OI Code	Enter the three digit carrier code of the other insurance.
13. OI Amount	Enter the dollar amount that all other insurance carriers have paid toward the services rendered on this claim line.
14. Units	Enter the number of units billed for the service on each claim line.
15. Rate	Enter the amount charged per unit of service on each claim line.

16. Charge	Enter the total amount charged for the service on each claim line (rate times units).
19. Total OI	Enter the total amount paid by all other insurance listed (in column 15) on all claim lines.
20. Total Charge	Enter the total amount of all the charges listed (in column 16) on all the claim lines.
Billing Provider Number	Enter the seven-character Medical Assistance number or National Provider Identifier (NPI) of the provider submitting the claim.
Billing Provider Name	Enter the first and last names of the provider submitting the claim.
Billing Provider Taxonomy	Enter the billing provider taxonomy. **Required if NPI is entered for billing provider.**
Performing Provider Number	Enter the seven-character Medical Assistance number or National Provider Identifier (NPI) of the provider who performed the service. This is required if a member of a group. (Leave blank if the same as billing provider.)
Performing Provider Name	Enter the first and last names of the provider who actually performed the service. (Leave blank if the same as field #1.)
Performing Provider Taxonomy	Enter the performing provider taxonomy. **Required if NPI is entered for performing provider.**